SOUND INPATIENT PHYSICIANS, INC. AND ITS AFFILIATED COVERED ENTITIES
REQUEST FOR ALTERNATIVE COMMUNICATIONS FORM

PATIENT NAME: _____

BIRTH DATE: _____

ADDRESS: _____

TELEPHONE: _____

PLEASE RESTRICT COMMUNICATION OF THE FOLLOWING PROTECTED HEALTH INFORMATION ABOUT THE ABOVE PATIENT:

_____

_____

PLEASE COMMUNICATE THE PROTECTED HEAL TH INFORMATION DESCRIBED ABOVE ONLY AS FOLLOWS:

_____

ALTERNATNE TELEPHONE NUMBER: _____

ALTERNATNE ADDRESS: _____

OTHER ALTERNATNE METHOD OF CONTACT: _____

_____

CHOOSE METHOD OF PAYMENT FOR COSTS RELATING TO ALTERNATNE COMMUNICATION:

□ Bill me □ Check or Money Order □ Credit Card

If you are not the patient, please fill out the following information:

Name: _____

Relationship to Patient: _____

Address (if different from above): _____

Telephone (if different from above): _____

Please furnish a copy of any conservator/guardianship papers with this request.

SIGNATURE: _____ **DATE:** _____

NOTE: *ALL REQUESTS FOR ALTERNATIVE COMMUNICATIONS MUST BE SUBMITTED IN WRITING ON THIS FORM. THE FORM SHOULD BE RETURNED TO THE PRIVACY OFFICER AT THE FOLLOWING ADDRESS:*

Sound Physicians
Attn: Chief Compliance & Privacy Officer
1498 Pacific Avenue, Suite 500, Tacoma, WA 98402
Phone: 1-855-768-6363
Email: compliance@soundphysicians.com

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Internal Use Only:

REQUEST IS: _____ APPROVED_____ DENIED

SIGNATURE:_____ DATE: _____

TERMINATION OF AGREEMENT:

DATE TERMINATED: _____

SIGNATURE: _____